1.0 Description of the Service

Personal Care Services-Plus (PCS-Plus) is an enhancement to the Personal Care Services (PCS) program. PCS-Plus is for recipients who have a qualifying medical condition and personal care needs that exceed the service limit for PCS. Services include assistance with personal care tasks such as bathing, toileting, ambulating, and monitoring vital signs. In addition, services such as housekeeping and home management tasks may be provided if they are essential to the personal care task(s) necessary for maintaining the recipient's health.

2.0 Eligible Recipients

2.1 General Provisions

Medicaid recipients may have service restrictions due to their eligibility category that would make them ineligible for this service.

2.2 Special Provisions

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that provides recipients under the age of 21 with medically necessary health care to correct or ameliorate a defect, physical or mental illness or a condition identified through a screening examination. While there is no requirement that the service, product or procedure be included in the State Medicaid Plan, it must be listed in the federal law at 42 U.S.C. § 1396d(a). Service limitations on scope, amount or frequency described in this coverage policy do not apply if the product, service or procedure is medically necessary.

The Division of Medical Assistance's policy instructions pertaining to EPSDT are available online at http://www.dhhs.state.nc.us/dma/prov.htm.

3.0 When the Service is Covered

Eligible recipients must qualify for PCS, require additional time for the in-home aide to perform delegated tasks, **and** meet one of the following three criteria for medical necessity:

- At a minimum, require extensive assistance in four or more Activities of Daily Living (ADLs).
- At a minimum, require extensive assistance in three or more ADLs **and** need the in-home aide to perform at least one task at the Nurse Aide II level.
- At a minimum, require extensive assistance in three or more ADLs **and** have a medical or cognitive impairment that requires extended time to perform needed in-home aide tasks.

See **Attachment A** for additional information on the PCS-Plus eligibility criteria.

4.0 When the Service is Not Covered

PCS-Plus is not covered when the individual does not meet one of the criteria listed in Section 3.0 or when the guidelines listed in **Section 5.0** are not followed. If an individual does not qualify for PCS-Plus, the DMA PCS-Plus Nurse Consultant will notify the PCS provider in writing of the denial.

5.0 Requirements for and Limitations on Coverage

- Up to 20 additional hours of PCS each month are covered for a recipient when DMA has issued a PCS-Plus prior approval. The PCS-Plus prior approval provides verification that the recipient meets the criteria listed in Section 3.0.
- PCS providers must obtain prior approval from DMA before initiating PCS-Plus services. PCS-Plus prior approvals are issued by the DMA PCS-Plus Nurse Consultant.
- The total number of PCS hours for a PCS-Plus recipient cannot exceed 80 hours in a calendar month.
- PCS providers may request prior approval for up to a 180-day period per recipient.
- To obtain prior approval for PCS-Plus, the PCS provider must follow the directions listed in **Attachment B**.

6.0 Providers Eligible to Bill for the Service

Home care agencies operating in North Carolina, licensed by the Division of Facility Services to deliver In-Home Aide services, and enrolled as Medicaid PCS providers, may provide additional PCS hours under the PCS-Plus program to eligible recipients.

7.0 Additional Requirements

PCS providers must use the PCS-Plus Request Form (DMA-3000-A) to submit their request for PCS-Plus services to DMA. There is also an optional nursing assessment worksheet (DMA-3000-B) available for PCS providers to document observations related to the need for PCS-Plus. See **Attachment C** for directions on how to complete the PCS-Plus Request Form.

8.0 Billing Guidelines

Reimbursement requires compliance with all Medicaid guidelines including obtaining appropriate referrals for recipients enrolled in Medicaid Managed Care programs.

8.1 Claim Type

For dates of services through July 31, 2004, providers bill professional services on the UB-92 claim form.

For dates of services beginning August 1, 2004, providers bill professional services on the CMS-1500 claim form.

8.2 Diagnosis Codes That Support Medical Necessity

Providers must bill the ICD-9-CM diagnosis code to the highest level of specificity that supports medical necessity. Diagnosis codes beginning with V (example: V700) are not acceptable and will result in a denial of the claim.

8.3 Procedure Codes

For dates of services through July 31, 2004, providers bill prior approved services with revenue code 599.

For dates of services beginning August 1, 2004, providers bill prior approved services with CPT procedure code 99509.

8.4 Reimbursement Rate

Provider must bill their usual and customary charges. For Medicaid billing, 1 unit of service = 15 minutes

9.0 Policy Implementation/Revision Information

Original Effective Date: November 1, 2003

Revision Information:

Date	Section Updated	Change
9/1/05	Section 2.0	A special provision related to EPSDT was added.
12/1/05	Section 2.2	The web address for DMA's EDPST policy instructions was added to this section.

Attachment A: Summary of Criteria for PCS-Plus

North Carolina Division of Medical Assistance (DMA)
PERSONAL CARE SERVICES-PLUS (PCS-PLUS) CRITERIA

Medicaid recipients who require additional time for the in-home aide to perform delegated tasks are eligible for PCS-Plus if they qualify for PCS and meet one of the following three criteria:

1. At a minimum require extensive assistance in four or more activities of daily living (ADLs). **OR**
2. At a minimum require extensive assistance in three or more ADLs *and* need the in-home aide to perform at least one task at the nurse aide II level. **OR**
3. At a minimum require extensive assistance in three or more ADLs *and* have a medical or cognitive impairment that requires extended time to perform needed in-home aide tasks.

The recipient's assessment must contain documentation that supports the PCS-Plus criteria.

The North Carolina Division of Medical Assistance (DMA) will interpret the PCS-Plus criteria as follows:

***Criterion 1*: Recipient meets PCS criteria AND requires at a minimum extensive assistance in four or more activities of daily living (ADLs).** (Note: Recipient could also be fully dependent in four or more ADLs or require a combination of extensive and fully dependent assistance needs in four or more ADLs.)

Activities of Daily Living include:

Bed mobility, transfer, ambulation, eating, toilet use, bathing, dressing, personal hygiene, and self-monitoring of medications.

- *Extensive assistance* is when a recipient requires weight-bearing support while performing part of an activity such as the guiding or maneuvering of limbs. *Extensive assistance also* refers to needing substantial or consistent "hands-on" assistance with eating, toileting, bathing, dressing, personal hygiene, and self-monitoring of medications.
- *Full dependence* is when a recipient cannot perform the activity and requires another individual to perform the entire activity.
- The definitions of extensive assistance and full dependence are based on the federally approved Minimum Data Set (MDS), 2.0 version.

***Criterion 2:* Recipient meets PCS criteria AND requires at a minimum extensive assistance in 3 or more ADLs (as defined above) AND requires at least one Nurse Aide II task.** (Note: DMA will evaluate the frequency of the Nurse Aide II tasks and expects that most recipients qualifying for PCS-Plus under Criterion 2 will require at least one Nurse Aide II task on a daily basis.

Nurse Aide II tasks are defined as any of the following:		
1. Oxygen Therapy	**4. Nutrition Activities**	**9. I.V. – Assistive Activities**
• Room set-up	• Oral/nasogastric infusions *(after placement verified by RN)*	• Assemble/flush tubing during set-up
• Monitoring flow-rate	• Gastrostomy feedings	• Monitoring flow-rate
2. Suctioning	• Clamping tubes	• Site care/dressing change
• Oropharyngeal	• Removing oral/nasogastric feeding tubes	• Discontinuing peripheral I.V. infusions
• Nasopharyngeal	**5. Sterile Dressing Change** *(Wound over 48 hours old)*	**10. Urinary Catheters**
3. Elimination Procedures	**6. Break-up & Removal of Fecal Impaction**	• Catherizations
• Ostomy Care	**7. Wound Irrigation**	• Irrigation of tubing
• Irrigation	**8. Tracheostomy Care**	

***Criterion 3:* Recipient meets PCS criteria AND requires at a minimum extensive assistance in 3 or more ADLs (as defined above) AND has a medical or cognitive impairment requiring extended time to perform needed in-home aide tasks.**

In this case, the **diagnosis** should include a medical or cognitive impairment that supports the in-home aide needing extended time. In addition, the assessment must document at least one of the following:

- Presence of continuous and/or substantial pain interfering with individual's activity or movement
- Dyspneic or noticeably short of breath with minimal exertion during the performance of ADLs and requires continuous use of oxygen
- Due to cognitive functioning, individual requires extensive assistance with performing ADLs. Individual is not alert and oriented or is unable to shift attention and recall directions more than half the time
- Bowel incontinence more often than once daily
- Urinary incontinence during the day and night

Attachment B: Initiating PCS-Plus Services

PCS agencies must obtain prior approval from DMA before initiating PCS-Plus services. PCS agencies may request prior approval for up to a 180-day period. To obtain prior approval for PCS-Plus, the agency must take the following steps:

1. When a referral is made to the PCS agency for PCS-Plus or when the PCS agency identifies a recipient in need of PCS-Plus, the PCS agency's RN evaluates the recipient's medical and functional need for PCS-Plus and documents the findings on the PCS-Plus Request form (DMA-3000-A). A copy of this form is available online at http://www.dhhs.state.nc.us/dma/forms.htm.

2. If the recipient is not currently receiving PCS, the PCS agency's RN must follow DMA's procedure for completing the DMA-3000 and obtaining the physician's authorization for PCS. Once the physician's authorization has been obtained, the PCS agency's RN can proceed with the request for PCS-Plus.

   Note: PCS-Plus prior approval is a Medicaid payment authorization and the agency's RN must determine if additional physician orders are needed to implement a pharmaceutical or medical regimen.

3. Completed PCS-Plus Request forms must be faxed to the DMA PCS-Plus Nurse Consultant at 919-715-2628.

4. The DMA Nurse Consultant reviews the PCS-Plus Request form (DMA-3000-A) to determine if the recipient qualifies for PCS-Plus. DMA will contact the PCS agency by fax or phone if additional information is needed to make a determination.

5. If the DMA Nurse Consultant determines that the recipient does not meet the criteria for PCS-Plus, the PCS agency is notified of the denial by e-mail or fax within seven workdays. The PCS agency must notify the recipient of the denial. The PCS agency may request a reconsideration review if additional information to support the recipient's need for PCS-Plus can be provided to DMA.

6. If the DMA Nurse Consultant determines that the recipient does meet the criteria for PCS-Plus, the PCS agency is notified of the prior approval by e-mail or fax within seven workdays. The prior approval specifies the number of approved PCS hours per month and the effective dates of PCS-Plus coverage (PCS-Plus authorization period). The agency must notify the recipient of the prior approval.

7. The agency must amend the recipient's DMA-3000 Plan of Care or an agency equivalent form to reflect the additional PCS-Plus hours.

8. At least one week before the PCS-Plus authorization expires, the agency must re-evaluate a recipient for PCS-Plus eligibility and submit a new PCS-Plus Request form (DMA-3000-A) to DMA for approval. PCS-Plus cannot be authorized for more than 180 days for each request.

Attachment C: Instructions for Completing the PCS-Plus Request Form

Note: Please print clearly on the form and sign the Nurse Assessor Certification in Section 8.

Section 1: PCS-Plus Request

- Indicate whether you are making a PCS-Plus Initial Request or PCS-Plus Reauthorization Request by checking the appropriate box.
- Enter the date.
- Enter your name (the name of the RN submitting the request).
- Enter the total number of PCS hours/month you are requesting for the recipient. For example, if the recipient is currently receiving 60 hours of PCS/month and you are requesting an additional 20 hours of PCS/month, enter 80.
- Enter the number of days that the recipient will require PCS-Plus.
- Specify the start date you are requesting for PCS-Plus and the appropriate end date. For example, if you are requesting 120 days of PCS-Plus and you intend to start services on 11/10/03, you would enter the following: From: **11/10/03** To: **3/8/04**
- Please note that PCS-Plus authorizations cannot exceed 180 days. To request an extension, you must submit a new PCS-Plus Request form at least one week before the PCS-Plus authorization expires.

Section 2: Provider Agency Information

- Enter the name of the PCS provider agency.
- Enter the agency's seven-digit Medicaid PCS provider number. This number begins with "66."
- Enter the agency's phone number, including area code.
- Enter the agency's fax number, including area code.
- Enter the agency's street address, including street, city, and zip code.
- Enter the e-mail address for the person (at the agency) who needs to be notified of the PCS-Plus approval or denial.

Section 3: Medicaid Recipient Information

- Enter the Medicaid recipient's last name as it appears on the Medicaid identification (MID) card.
- Enter the Medicaid recipient's first name as it appears on the MID card.
- Enter the Medicaid recipient's middle name as it appears on the MID card.
- Enter the Medicaid recipient's street address, including street, city, and zip code.
- Enter the name of the county in which the Medicaid recipient resides in.
- Enter the Medicaid recipient's phone number or a number through which the recipient can be contacted. Be sure to include the area code.
- Enter the recipient's identification number (nine-digits + one alpha character) from the MID card.
- Enter the month/day/year for the recipient's date of birth.
- Indicate whether the recipient is currently receiving PCS by checking the Yes or No box. If the client is not currently on PCS, you must follow DMA procedures for completing the DMA-3000 and obtaining physician authorization for PCS before submitting the PCS-Plus Request form.
- Enter the name of the recipient's attending physician.
- Enter the phone number of the recipient's attending physician.
- Enter the date that the recipient's DMA-3000 was signed by the attending physician.

Section 4: Primary and Secondary Diagnosis

- Enter the recipient's primary and secondary diagnosis.
- If a medical or cognitive condition is being used to qualify the recipient for PCS-Plus, the assessment must document at least one of the conditions listed in Section 4. Check all the conditions that apply to the recipient.
- If a medical or cognitive condition is not being used to qualify the recipient for PCS-Plus, check the box labeled "Not Applicable."

Section 5: Current Medications

- List the name, dose, frequency, and route of administration for all prescription medications currently taken by the recipient.
- List over-the-counter medications if there is space available. Any over-the-counter medication that supports the recipient's medical diagnosis must be also listed.

Section 6: Limitations in Activities of Daily Living

- Rate the recipient's ADL Self-Performance using the ADL Self-Performance Scores listed in Section 6.A. The scores range from 0-4. Enter the score for each ADL under the column labeled "ADL Self-Performance." This column is the second column from the right under Section 6. For example, if a recipient is independent and does not require any help or oversight in Bed Mobility, you would enter 0 under the ADL Self-Performance column that corresponds to line 6a. Bed Mobility.
- Rate the recipient's ADL Support Provided using the ADL Support Scores listed in Section 6.B. The scores range from 0-3. Enter the ADL Support Provided score under the column labeled "ADL Support-Provided". This column is the first column from the right under Section 6. For example, if a recipient requires a one person physical assist in toilet use, you would enter 2 under the ADL Support Provided column that corresponds to line 6e., Toilet Use.
- In Section 6c., Ambulation, be sure to enter the type of assistive equipment used, if applicable. Examples of assistive equipment include walkers, wheelchairs or Hoyer lifts.
- In Section 6d., Eating, be sure to enter the type of therapeutic diet, if applicable.

Section 7: Nurse Aide II Tasks

- In the space provided, specify any Nurse Aide II tasks that the recipient requires. Be sure to identify the frequency of the task (daily, weekly, etc.).
- If Nurse Aide II tasks are not being used to qualify the recipient for PCS-Plus, enter "Not Applicable" in this section.
- Nurse Aide II tasks are physician ordered and must be included on your DMA-3000 or physician order.

Section 8: Nurse Assessor Certification

- The nurse assessor completing the PCS-Plus Request Form must complete this section.
- In the certification statement, enter the date that the recipient's DMA-3000 was signed by the attending physician.
- The nurse assessor must print his/her name and sign and date the certification.

DMA Prior Approval (Box located in the upper right hand corner of the form)

- **Do not complete this section.**
- The DMA Prior Approval Section will be completed by the DMA Nurse Consultant after the agency has faxed the form to DMA for review.